Open Enrollment 2012

Non-Medicare Options
State Employee Health Plan

Plan A, Plan B and other information

Comparison Chart 1

If you do not wish to make any changes to your coverage, you do not need to complete and submit an enrollment form.

For Retiree/Direct Bill Members

Kansas
Department of Health and Environment
Division of Health Care Finance

Monthly Premiums (Plan A, Superior Vision and Delta Dental Service) ①

Coverage Choice	Monthly Medical Plan A Premiums			Monthly Superior Vision Premiums		Monthly Delta Dental Premiums
	Blue Cross Blue Shield of Kansas Plan A	Coventry/PHS Plan A	UnitedHealthcare Plan A	Superior Vision Basic Plan	Superior Vision Enhanced Plan	
1	$546.25	$562.64	$573.56	$4.36	$7.26	$21.49
2	$1,147.16	$1,181.57	$1,204.52	$8.72	$14.52	$48.55
3	$983.27	$1,012.77	$1,032.43	$7.86	$13.06	$53.94
4	$1,638.78	$1,687.94	$1,720.72	$12.20	$20.32	$86.31
B	$491.36	$501.56	$501.95	$6.54	$10.89	$21.49

Monthly Premiums (Plan B, Superior Vision and Delta Dental Service)

Coverage Choice	Monthly Medical Plan A Premiums			Monthly Superior Vision Premiums		Monthly Delta Dental Premiums
	Blue Cross Blue Shield of Kansas Plan B	Coventry/PHS Plan B	UnitedHealthcare Plan B	Superior Vision Basic Plan	Superior Vision Enhanced Plan	
1	$511.29	$527.68	$538.60	$4.36	$7.26	$21.49
2	$1,073.74	$1,108.16	$1,131.10	$8.72	$14.52	$48.55
3	$920.34	$949.84	$969.50	$7.86	$13.06	$53.94
4	$1,533.90	$1,583.06	$1,615.84	$12.20	$20.32	$86.31
B	$459.91	$465.19	$474.83	$6.54	$10.89	$21.49

Coverage Choice Codes Key

1 - Member Only 2 - Member and Spouse Only 3 - Member and Child(ren) Only 4 - Member, Spouse and Child(ren) B - Medicare Member Only

IMPORTANT REMINDERS:

The premiums provided for vision and dental coverage above are separate from the premiums provided for the medical plans. Therefore, when calculating your total monthly premium, please be sure to add all three premium amounts, as applicable.

Health Plan Comparison Chart ②

	Plan A	Plan B
	Blue Cross and Blue Shield Coventry/PHS UnitedHealthcare	Blue Cross and Blue Shield Coventry/PHS UnitedHealthcare

	Network Providers	Non Network Providers	Network Providers	Non Network Providers
Basic Provisions				
Provider Choice	Freedom to use provider of choice, benefits based on plan description: coverage level based on provider network status			
Annual Deductible: not included in Coinsurance maximums in Plans A & B	$300 single/$600 family	$500 single/$1,500 family	$150 single/$300 family	$500 single/$1,500 family
Coinsurance *(for all eligible expenses, unless otherwise noted)*	20% Coinsurance	50% Coinsurance	35% Coinsurance	50% Coinsurance
Annual Coinsurance Maximum *(does not include deductible and Copayments)*	$1,400 single/$2,800 family	$3,650 single/$7,300 family	$3,000 single/$6,000 family	$3,650 single/$7,300 family
Annual Out-of-Pocket Maximum	N/A	N/A	N/A	N/A
Lifetime Benefit Maximum	No limit	No limit	No limit	No limit
Amounts Above Plan Allowance	Provider to write off	Member responsibility	Provider to write off	Member responsibility
Preventive Care - *Limited to one visit or service per year unless otherwise noted. Review the benefit description for details on exact coverage.*				
Well Baby Exams - *includes newborn screenings & age appropriate office visits*	Covered In Full	Not covered	Covered In Full	Not covered
Well Child Exam - *includes office visit, age appropriate screenings and counseling*	Covered In Full	Not covered	Covered In Full	Not covered
Well Woman Exam - *includes office visit, age appropriate screenings and counseling*	Covered In Full	Not covered	Covered In Full	Not covered
Well Man Exam - *includes office visit, age appropriate screenings and counseling*	Covered In Full	Not covered	Covered In Full	Not covered ③
Prenatal Screenings and Counseling - *See benefit description for list of covered services*	Covered In Full	Not covered	Covered In Full	Not covered
Age Appropriate Bone Density Screening	Covered In Full	Not covered	Covered In Full	Not covered

Immunizations	Covered In Full	Covered in full to age 6 otherwise Deductible plus 50% Coinsurance.	Covered In Full	Covered in full to age 6 otherwise Deductible plus 50% Coinsurance.
Mammography - *(not limited to one)*	Covered In Full	Deductible and Coinsurance	Covered In Full	Deductible and Coinsurance
Colonoscopy - *(not limited to one)*	Covered In Full	Not covered	Covered In Full	Not covered
Ultrasonography for Aortic Aneurysm - *limited to men ages 65 to 75 with history of tobacco use*	Covered In Full	Not covered	Covered In Full	Not covered
Routine Hearing Exam	Covered In Full	Not covered	Covered In Full	Not covered
Routine Vision Exam	Covered In Full	Not covered	Covered In Full	Not covered
Covered Services				
Inpatient Services	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance
Physician Hospital Visits	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance
Physician Office Visits Primary Care Provider	$25 Copayment	Deductible & 50% Coinsurance	Adults: $20 Copayment/ Dependent children age 18 and under: $10 Copayment	Deductible & 50% Coinsurance
Specialist	$45 Copayment	Deductible & 50% Coinsurance	Adults: $40 Copayment / Dependent children age 18 and under: $25 Copayment	Deductible & 50% Coinsurance
Urgent care center	$25 Copayment, Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	$20 Copayment, Deductible & 35% Coinsurance	Deductible & 50% Coinsurance
Outpatient Surgery	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance
Emergency Room Visits	$100 Copayment (waived if admitted) then Deductible & 20% Coinsurance	$100 Copayment (waived if admitted) then Deductible & 20% Coinsurance	$100 Copayment (waived if admitted) then Deductible & 35% Coinsurance	$100 Copayment (waived if admitted) then Deductible & 35% Coinsurance (4)
Other Outpatient Services	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance
Ambulance Services	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 35% Coinsurance	Deductible & 35% Coinsurance
Major Diagnostic Tests	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance

X-Ray and Laboratory	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance
Rehabilitation Services: *(services limited to those medically necessary and appropriate: medical records must show continued improvement)*				
Inpatient facility	Deductible & 20% Coinsurance	$600 Copayment, Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	$600 Copayment, Deductible & 50% Coinsurance
Outpatient facility	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance
Office based	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance
Durable Medical Equipment	Deductible & 20% Coinsurance: limited to $5,000 per person per year	Deductible & 50% Coinsurance: limited to $5,000 per person per year	Deductible & 35% Coinsurance: limited to $5,000 per person per year	Deductible & 50% Coinsurance: limited to $5,000 per person per year
Allergy Testing	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance
Antigen Administration: *desensitization/treatment; allergy shots*	Covered in full	Deductible & 50% Coinsurance	Covered in full	Deductible & 50% Coinsurance
Autism Services	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance
Manipulation Therapies	Deductible & 20% Coinsurance: limited to 30 visits per year	Deductible & 50% Coinsurance: limited to 30 visits per year	Deductible & 35% Coinsurance: limited to 30 visits per year	Deductible & 50% Coinsurance: limited to 30 visits per year
Licensed Dietitian Consultation: *for medical management of a documented disease*	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance
Hospice *services must be pre-approved by health plan; limited to six months*	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance
Preferred Lab Benefit	*The Preferred Lab Benefit program is included when you choose either Plan A or Plan B as a way to save you money on outpatient laboratory tests. When you use a collection site of either Quest Diagnostics (state and nationwide) or Stormont Vail Health Care (8 locations in NE Kansas) for outpatient lab work covered by Plan A or Plan B, the cost will be covered at 100 percent of the negotiated amount with no deductible, copayment or coinsurance. Eligible services will be identified by your health plan and paid in full.*			

Mental Health				
Mental Illness & Drug or Alcohol Treatment	Same as Medical	Same as Medical	Same as Medical	Same as Medical (5)

The comparison chart is NOT the governing document. Members need to refer to each Provider's Benefit Description posted at ***www.kdheks.gov/BenefitDescriptions***

Caremark Prescription Drug Benefits for Plan A and Plan B

Tier	Type of Prescription Medication	You Pay	Your Out of Pocket Maximum
Tier 1	**Generic drugs**	20% coinsurance	There is a combined coinsurance maximum of $2,580 per person/year that applies to Tiers 1, 2 and 3
Tier 2	**Preferred brand name drugs**	35% coinsurance	
Tier 3	**Special case medications** (Very high-cost medications used to treat conditions that are generally life threatening)	Maximum of $75 per standard unit of therapy	
Tier 4	**Non preferred brand name drugs**	60% coinsurance	n/a (unless an override has been granted by Caremark)
Tier 5	**Lifestyle medications** (Medications used primarily to enhance lifestyle rather than treat an illness or condition)	100% of discounted price	n/a
No Tier	**Anti-Cancer Oral Medications**	25% coinsurance to a maximum of $75 per standard unit of therapy	Separate coinsurance maximum of $750 per member per year
Value Based	**Diabetes**	**Generic** - 10% to a maximum of $10 / 30-days **Preferred Brand** - 20% to a maximum of $20 / 30-days	Applies to the $2,580 coinsurance maximum
Value Based	**Asthma**		

Delta Dental Benefits

	Delta Dental PPO Network Provider	Delta Dental Premier Network Provider	Non Network* Provider
Annual Benefit Maximum	$1,700 per member		
Lifetime Orthodontic Benefit Maximum	50% Coinsurance to a maximum of $1,000 per member		
DEDUCTIBLE			
Diagnostic and Preventive Services	No Deductible		
Basic Restorative Services	$50 per person per Plan year Not to exceed an annual family deductible of $150		
Major Restorative Services			
COINSURANCE			
BASIC BENEFIT **Applies when you have NOT had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior 12 months**			
Diagnostic and Preventive Services	Allowed Amount covered in full by the Plan*		
Basic Restorative Services	50%	50%	50%
Major Restorative Services	50%	50%	50%
ENHANCED BENEFIT **Applies when you have had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior 12 months**			
Diagnostic and Preventive Services	Allowed Amount covered in full by the Plan*		
Basic Restorative Services	20%	40%	40%
Major Restorative Services	50%	50%	50%

**Services by Non Network providers are subject to the Allowed Amount including the Maximum Plan Allowance for Non Network Providers. Any amounts in excess of the Allowed Amount will be the member's responsibility.*

Your coinsurance will increase for Basic Restorative Services when you have not had a routine prophylaxis (cleaning) and/or preventive oral exam in the preceding twelve (12) month period. Ninety (90) days following receipt of a qualifying prophylaxis (cleaning) or preventive oral exam, you will qualify for the Enhanced Benefit Level. The Plan reserves the right to determine what services will qualify as meeting the definition of a routine prophylaxis (cleaning) and preventive oral exam. Routine prophylaxis (cleanings) and preventive exams shall not include any services provided on an emergency basis or for treatment of an injury to the teeth.

Vision Benefits

Service or Item	Basic Plan: Network	Enhanced Plan: Network	Both Plans: Non Network
Eye Exams: Subject to $50 Copayment			
• Eye exam, M.D.	Covered in full after Copayment	Covered in full after Copayment	Up to $38
• Eye exam, O.D.	Covered in full after Copayment	Covered in full after Copayment	Up to $38
Eyeglasses: Subject to $25 materials Copayment			
• Frame	Up to $100 retail*	Up to $100 retail*	Up to $45
• Single vision lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to $31
• Bifocal lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to $51
• Trifocal lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to $64
• Lenticular lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to $80
• Progressive lenses, pair	Not covered	Covered up to $165*	Not covered
• High index lenses, pair**	Not covered	Covered up to $116*	Not covered
• Polycarbonate lenses, pair**	Not covered	Covered up to $116*	Not covered
• Scratch coat	Not covered	Covered in full	Not covered
• UV coat	Not covered	Covered in full	Not covered
Contact Lenses: Not subject to materials Copayment			
• When medically necessary	Covered in full	Covered in full	Up to $210 retail*
• Elective/cosmetic retail	Up to $150 retail*	Up to $150 retail*	Up to $105 retail*
Contact Lens Exam (fitting fee) ($35 Copayment)			
• Specialty contacts***	Not Covered	Up to $50*	Not Covered
• Standard Contacts****	Not Covered	Covered in full	Not Covered

**You are responsible for any charges above the allowance.*
*** You may only be covered for one pair of high index lenses or polycarbonate lenses under the Enhanced Plan (up to the allowance provided above).*
**** Specialty contacts are for new contact lens wearers or patients who wear toric, gas permeable or multi-focal lenses; includes two follow-up visits within three months of initial fitting.*
***** Standard contacts are for existing contact lens wearers of disposable, daily wear or extended lenses; includes two follow-up visits within three months of initial fitting.*

Notes:
• Members can use either the contact lens benefit or the eyeglass benefit, but not both in the same plan year.
• For non network claims, copayment amounts are deducted from the benefit allowance at the time of reimbursement.
• Covered lenses are standard glass or plastic (CR-39), clear.